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SIMULATING

## OVARIAN SARCOMA WHEN EXPLORED BY ABDOMINAL SECTION.

RECOVERY WITH DISAPPEARANCE OF THE CYST.

BY

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# ANTERIOR SEROUS PERIMETRITIS SIMULATING OVARIAN SARCOMA WHEN EXPLORED BY ABDOMINAL SECTION. RECOVERY WITH DISAPPEARANCE OF THE CYST.

By Alban Doran.

(Received April 6th, 1889.)

R. L—, aged 16, domestic servant, was sent to me on May 3rd, 1887, by my friend Dr. Ilott, of Bromley, Kent, who informed me that he had discovered that she was suffering from some form of abdominal tumour.

The patient was rather tall and slender, dark haired, and of a pale, unhealthy complexion. I could find no evidence of chronic tonsillitis or enlargement of the cervical glands. Her family was of a delicate constitution; a younger brother had recently died of tuberculosis. In the middle of April, 1887, her period did not appear. The abdominal swelling was then discovered, and pregnancy suspected. She admitted to her mother that she had frequently had connection with a youth of about her own age. In three weeks the tumour became very large.

I found the patient's abdomen distended. There was resonance in the flanks, and also along the middle line from the ensiform cartilage to a little below the umbilicus. The lower part of the abdomen was filled by a soft fluctuating tumour. Its upper border extended to the umbilicus above the lowest level of resonance.

Measurements on May 3rd: Umbilical level, 30 in. Two inches below umbilicus, 31½ in. Ensiform cartilage to umbilicus, 6 in. Umbilicus to symphysis pubis, 7½ in.

Right anterior superior spine of ilium to umbilicus, 7½ in. Left ditto to umbilicus, 7¾ in.

The vagina was capacious, the rugæ effaced. The uterus lay high in the pelvis; tho cervix was small. The sound could be introduced for nearly three inches. The uterus was quite moveable, but every movement of the tumour was communicated to the sound. The tumour did not descend into the pelvis.

The patient's tongue was bright red and glossy. Her appetite was peculiar; she preferred chewing pills to swallowing them. The mammæ were well formed, but showed no signs of enlargement.

I saw her once more on May 31st. The fluctuation in the tumour was less distinct, and it felt harder along its right and left limits. Measurements: Umbilicus, 29 in. Two inches below umbilicus, 29½ in. Ensiform cartilage to umbilicus, 5¾ in. Umbilicus to symphysis pubis, 8½ in. Right spine of ilium to umbilicus, 7 in. Left ditto to umbilicus, 7 in. Thus the tumour had decreased in bulk, except in one direction, having gained one inch between the umbilicus and the pubes. I took care to measure the abdomen myself on every occasion.

On June 16th she was admitted into Mrs. Mann's Nursing Home, Devonshire Street. Once more the tumour had undergone alteration. Fluctuation was again distinct. Measurements: Umbilicus, 31½ in. Two inches lower, 32½ in. Ensiform cartilage to umbilicus, 6¾ in. Umbilicus to symphysis pubis, 9 in. Right spine of ilium to umbilicus, 9 inches. Left ditto to umbilicus, 8¾ inches. Thus the measurements had increased in every direction, exceeding their extent on May 3rd. The bulging below the umbilicus alone had steadily increased. The girth had increased after diminishing. Tho flank measurements showed the greatest proportional and absolute increase. The temperature was 99°, pulse 84. The catamenia had never appeared since March. Tho patient looked more cachectic than in May.

I determined to explore by abdominal section. I believed

that the tumour was most probably a cystic sarcoma of the ovary with a short pedicle. The disease is not rare in young girls, and is generally attended with amenorrhœa, as Leopold and others have noted. The tumour was so distinctly circumscribed, apparently moveable, and not complicated by any of the pelvic symptoms of perimetritis or parametritis that I could not bring myself to believe that it was a product of inflammation or abnormal gestation, and not a new growth.

On June 18th I operated, assisted by Drs. Bantock and Ilott; chloroform was administered by Mr. Stormont Murray. In dividing the transversalis fascia, the peritoneum, which could be recognised by the urachus, was found to be extremely thick. When divided, some rather firm spongy tissue was incised. It was of a dull yellow colour and oozed freely. These appearances tended to confirm my previous impressions. As the peritoneum was adherent to, or rather incorporated with, the growth, and as the pelvic symptoms indicated close connection with the uterus, I thought it best to close the abdominal wound, and in this decision I was supported by the gentlemen who assisted me.

The young girl made a rapid recovery, her temperature never exceeding 99·6°, nor her pulse 84. Flatus passed freely on the second day, and there was no trouble when her bowels were opened on June 25th. Her tongue remained very red, and she suffered occasionally from heartburn during convalescence, but she was subject to dyspepsia, and the hot weather (for the operation was performed in Jubilee week) was trying to her. On June 30th she left the Nursing Home in improved general health. I gave her mother a gloomy prognosis.

On September 21st, 1888, fifteen months after the operation, to my great surprise, I saw the patient once more. Her mother told me that profuse vaginal discharge occurred shortly after she left the Nursing Home. The swelling then diminished, but the patient grew weaker. Dr. Ilott recommended her to see me again. The catamenia had

never reappeared, nor have they yet been seen (April, 1889).

The patient had grown and gained flesh, but was still anæmic, and made herself out to be unfit for any employment. The tongue was still very red and glossy.

On examination, I found that no trace of the tumour could be detected. The uterus was bulky, anteverted, and fairly, but not freely, moveable. There was a sensation of fulness on each side of the cervix.

The patient has remained under my observation since October. On March 26th, when last examined, the uterus was anteflexed, the body slightly enlarged and displaced to the left. No tumour nor any uncircumscribed deposit could be detected in the abdomen. I did not introduce the sound, as on every occasion when I saw the patient she had to return at once by train to Bromley. I believe, on substantial grounds, that the sound may do much harm under such circumstances. The girl complained of pain some time after taking liquid food, a frequent symptom when old peritoneal adhesions exist.

In this case an exploratory operation was not sufficient for diagnostic purposes. I succeeded in detecting the outer surface of the parietal peritoneum, and I made out that it was much thickened. The thickening was probably even greater than was apparent. What looked on section so like the sarcomatous strongly-adherent wall of an ovarian tumour was really either the deeper part of the parietal portion of the peritoneum or omentum, altered by old inflammation. Had I cut a little deeper I might have come upon a collection of fluid, and then the diagnosis would have been different and the exposed cavity could have been drained. From experience, however, I know that meddling with a growth which appears malignant is very dangerous. I once laid open a secondary cyst in a large ovarian tumour which was malignant and irremovable. I removed all the solid growths from the wall of the cyst, sewed its edges to the abdominal wound, and drained. Though the patient recovered and lived several months,

the case gave me much anxiety. In the present instance the tumour was not bulky as in the case just noted, and there was no object in lessening its bulk. Had I recognised the true nature of the present case, the sequel proves that emptying the fluid would have been unnecessary, if not dangerous. The temperature was low ; there was no clear evidence of abscess. Lastly, I might have cut through more important structures had I proceeded further. The exploration did no harm ; perhaps it hastened resolution of the fluid ; perhaps the cutting of the thickened serous membrane proved beneficial.

The true nature of the " tumour " merits consideration. Was it a sarcoma which underwent spontaneous cure? This is against all pathological and clinical experience. Was it a soft fibroid which disappeared ? Dr. Matthews Duncan has noted the disappearance of fibroids, but the age and history of the case at least contradict such a hypothesis. After seeing the patient again in October, I thought, for a time, that the tumour might have been an extra-uterine sac, the sarcoma-like tissue being degenerate placenta. The history before and after the exploration was, however, quite unlike the course of events in ectopic gestation. There was no acute pain, the pelvis was free from any objective sign of abnormal gestation, fluctuation is rare in a fœtal sac, and, lastly, the fœtus and placenta would hardly disappear so as to be impalpable fifteen months after exploration.

In cases of anterior parametritis where the sub-peritoneal connective tissue between the pubes and the umbilicus is involved, a cuirass-like deposit rather than a circumscribed cystic tumour is felt. In my case the urachus was plainly seen on the anterior surface of the thick layer, which was divided by the scalpel. Hence that layer could not have been subserous connective tissue. The uterus was freely moveable at the time of exploration, a very unusual, if not impossible, condition in parametritis.

The after-history contra-indicates tubercular disease of the abdominal or pelvic viscera. The patient is still a

delicate girl, but tubercular peritonitis would hardly have undergone spontaneous cure under the circumstances, for her general health remains weak, and she has not been leading a very healthy life. In fact, had the disease in 1887 been tubercular she would have hardly lived till now, or at least would have most probably grown worse.

I believe that the disease was anterior serous peritonitis. I employ the term as understood by Dr. Matthews Duncan. I think that the tumour was a circumscribed collection of fluid bounded by thickened peritoneum and extremely thickened omentum* anteriorly. This condidition was brought about by some uterine trouble, possibly originating in early abortion or gonorrhœa. I do do not think that it was unconnected with uterine disease; in other words, it is more correctly to be termed "serous perimetritis" than "encysted dropsy."

In the twenty-ninth volume of the Society's 'Transactions' (1887), p. 149, is an interesting woodcut representing a case of anterior perimetritis. The specimen was exhibited by Dr. W. S. A. Griffith. In my own case the condition was, I suspect, very similar. The absence of any vesical trouble was remarkable, irritability of the bladder being almost constant in subacute and chronic forms of anterior perimetritis. The most doubtful feature in my case was the absence of any part of the tumour from the pelvis. In Dr. Griffith's illustration just noted, the serous collection has forced its way downwards in a singular manner. Indeed, the lower limits of the utero-vesical pouch appear to have absorbed the cellular tissue between the bladder and cervix, so that it reaches the anterior vaginal wall. This condition is described as "extension of abscess into anterior parametric region"—the contents of the cyst being evidently purulent. In my case the lower part of the tumour did not descend into the pelvis. Perhaps some intestine, occupying the

* Specimens in the Pathological Collection, Mus. R. C. S., series xxi, "Injuries and Diseases of Peritoneum," show how greatly the omentum may be altered by disease.

utero-vesical pouch, lay below the encysted fluid. More probably the pouch was effaced by adhesive inflammation. The profuse vaginal discharge might have been pus or serum escaping through the Fallopian tube, but the patient was not under the care of any medical man when it occurred, so that no accurate exploration of the phenomenon could be obtained.

The case bears a resemblance in some respects to another recorded by Forget, of Strasburg, and quoted by Dr. Matthews Duncan in his 'Practical Treatise on Perimetritis and Parametritis.' The patient died of cancer of the body of the uterus at the age of sixty-two. Seven years before death ovarian dropsy was diagnosed, and she was tapped four times. After death an ovoid cavity was discovered, full of "a yellow limpid serosity." Its anterior boundary was the great omentum thickened and adherent to the parietal peritoneum. It represented anterior perimetritis and must have preceded the cancer, whatever may have been its cause.